On Plain Language and Going Astray

To the Editor:

Stage classification is a nomenclature to describe the anatomic extent of tumors and nothing more. It provides a language; however, the nature of what is described is not affected by the language used. A "seven-cm tumor in the left upper lobe without nodal metastases" (English) is the same thing as a "sieben cm Tumor im linken Oberlappen ohne Lymphknotenmetastasen" (German). Similarly, a "7-cm T2N0M0 tumor" (6th edition classification) is the same thing as a "7-cm T3N0M0 tumor" (7th edition classification). As long as we remember that the stage classification is simply a nomenclature to describe anatomic tumor extent, we do not get led astray.

We use the stage classification nomenclature as a tool in estimating prognosis, because the anatomic tumor extent is an important component influencing this. But there are many other factors, such as performance status, histology, prognostic factors, comorbidities, and perhaps most importantly, the treatment given (at least we like to believe that it makes a difference).

One can look at only one factor in isolation, such as the anatomic tumor extent, and then describe prognosis in an overall collective of patients with a mixture of other prognostic factors, comorbidities, and treatments given. In fact, this approach was used as a tool in developing the stage categories. However, recognizing the heterogeneity of such overall collectives grouped only by anatomic tumor extent, the staging committee wisely set the criteria for determining the classification descriptors and groupings to be differences in prognosis that were consistent within various subpopulations (e.g., histologic type, geographic region) and not the prognosis of the heterogeneous collectives as a whole. The figures depicting the collective prognosis of a stage group should not obscure the fact that this is a somewhat abstract measure that is not directly applicable to a particular patient, with particular prognostic features, undergoing a particular treatment.

Furthermore, we should not get misled in making assumptions about the treatment received in the stage classification database; in fact, this is likely to have been quite heterogeneous. In approaching individual patients in our clinics today, we should weigh the prognosis, taking into account all factors, and the outcomes with a particular treatment, which are available from up-to-date clinical trials (and not from the stage classification per se, involving patients treated between 1990 and 2000).

The fact that differences in prognosis were used as a tool to develop the stage classification and that the anatomic extent of disease (i.e., stage classification) is used as a tool in describing prognosis or to describe the patients who received a particular treatment in a study does not mean that stage classification defines the prognosis or the treatment for each patient falling within a stage cohort. I worry that the editorial "The 7th TNM Staging System and Lung Cancer Treatment Choices"[1] does not make this distinction clearly enough and allows us to continue to fall prey to this mistake. If we view stage classification only as a nomenclature to describe anatomic tumor extent, we do not get led astray.

Frank C. Detterbeck, MD
Yale University School of Medicine
Thoracic Surgery
New Haven, CT

Disclosure: The author has no potential conflicts to disclose, other than being a member of the methodology subcommittee of the International Staging committee.

Address for correspondence: Frank C. Detterbeck, MD, Yale University School of Medicine, Thoracic Surgery, 330 Cedar Street BB 205, New Haven, CT 06520-8062. E-mail: Frank.detterbeck@yale.edu

ISSN: 1556-0864/11/0603-0650

REFERENCE

1. Vansteenkiste JF, Shepherd FA. The seventh tumor, node, metastasis staging system and lung cancer treatment choices. A matter of would, could, and should. *J Thorac Oncol* 2010;5:1724–1725.

Reply to "On Plain Language and Going Astray"

In Reply:

We thank Dr. Detterbeck for his further reflections on the period of change in tumor, node, metastasis (TNM) we are faced with. From a theoretical point of view, we largely agree with his comments.

Stage classification, indeed, is an anatomic description of malignant disease, and it is only one element to estimate the prognosis; however, it is a major one. Several other factors—listed in Dr. Detterbeck's comment—indeed have the consequence that stage defines the average prognosis of a stage group and not of a particular patient and that important treatment heterogeneity may be present within a stage.

Likewise, it is true that we prefer to base our treatment decisions on up-to-date clinical trials, but in cases where these decisions are stage dependent (adjuvant chemotherapy for a patient with completely resected N0 non-small cell lung cancer as a typical example), we have to rely on the most up-to-date staging system for this decision. This is where the difficulty and the practical questions of many clinicians start as illustrated in the article of Dr. Daniel Boffa, which we commented on.[1] Much of the change from TNM6 to TNM7 in early stages relates to the size of the primary tumor, and most of the adjuvant chemotherapy trials do not have detailed data on this tumor size to compare the treatment outcome results in TNM6 or TNM7. Consequently, making the optimal link between existing clinical trial data and how to use these in a time interval with a different stage classification is difficult, until new data with more details on tumor size and other clinical and laboratory factors become available.

Disclosure: The authors declare no conflicts of interest.

Address for correspondence: Johan F. Vansteenkiste, MD, PhD, Respiratory Oncology Unit (Pulmonology), University Hospital Gasthuisberg, Herestraat 49, B-3000 Leuven, Belgium. E-mail: johan.vansteenkiste@uzleuven.be

ISSN: 1556-0864/11/0603-0650